nents over baseline. On the Bosch calculated single index, cilostazol was better than pentoxifylline and placebo. Pentoxifylline had a lower calculated QALY score than cilostazol or placebo. Based on this model, cilostazol had an incremental cost per QALY of $72,153 over placebo and $21,294 over pentoxifylline. As expected the model is sensitive to changes in price and utilities, and patients who have substantial improvements in QOL scores over baseline have better cost per QALY results. From a managed care perspective with a patient co-pay of 20%, the patient's incremental cost of cilostazol over placebo was $14,431 per QALY and the managed care plan cost is $57,722 per QALY. **CONCLUSION:** Based on this analysis of treatments for intermittent claudication, cilostazol had a reasonable incremental cost per QALY over pentoxifylline or placebo. Lower cost per QALY results can be obtained by continuing on therapy patients who attain higher than average gains in quality of life scores from baseline.

PCV8

PATIENT COMPLIANCE WITH DIFFERENT PRESCRIBED REGIMENS OF DILTIAZEM IN ANGINA PECTORIS: DATABASE ANALYSIS IN FRANCE

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OBJECTIVE: Patient compliance is an important component in the successful management of any disease. In general, it is assumed that in disease states involving periodic, intense pain, such as angina pectoris (AP), compliance rates would be high, and unaffected by dosing regimen. We verified this hypothesis by examining the compliance rates of patients taking different formulations (o.d. (200–300mg), b.d. (90–120mg) and t.d.s. (60mg)) of diltiazem (princeps) for AP. **METHOD:** We performed a retrospective analysis of 3455 electronic patient records with a diagnosis of AP and a prescription of diltiazem (princeps) from June 1st 1997 to June 1st 1998 (Mediplus-IMS Health) with a one-year follow-up. The above patient cohort was then divided into 3 subgroups according to the different formulation taken. The two subgroups b.d. and t.d.s. were paired to the third one, according to 4 criteria: age, sex, disease history and comorbidities. Compliance was assessed using initial prescription and refill rates ((pills dispensed/daily dose)/duration of therapy). **RESULTS:** The proportion of patients showing "good compliance" (> 0.8) was significantly higher for the o.d. versus b.d. (36.1% versus 25.9%, $p = 0.001$) and for the o.d. versus t.d.s. (36.1% versus 27.1%, $p = 0.008$). We observed the same trend when we compared the mean rate of compliance for the o.d. versus b.d. (0.62 versus 0.55, $p = 0.0027$) and for the o.d. versus t.d.s. (0.62 versus 0.60, $p = 0.0121$). **CONCLUSION:** Even for life threatening cardiac disease like AP, dosing regimens have a significant effect on compliance. Giving diltiazem as an o.d. formulation could significantly improve compliance and potentially decrease health care resources used.

PCV9

AN ECONOMIC ANALYSIS OF CONGESTIVE HEART FAILURE (CHF) IN THE LOUISIANA MEDICAID PROGRAM

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OBJECTIVE: To examine the cost of illness of Congestive Heart Failure (CHF) in the Louisiana Medicaid program. **METHODS:** Study design: A retrospective review of the medical and pharmacy claims data (1999–2000) in the Louisiana Medicaid program. We reviewed pharmacy and medical claims data for the years 1999–2000 from the Louisiana Medicaid program. The data were obtained from Unisys, the fiscal intermediary for the Louisiana Medicaid program, in a PC compatible format. We extracted the claims for CHF patients on the basis of the ICD-9-CM codes. A total of 13,947 patients met the study criteria, which included at least one primary or secondary diagnosis of CHF and availability of claims data for at least one year after the first CHF diagnosis related claim. We reviewed all the charges incurred for a one-year period after the initial CHF claim. **RESULTS:** The total cost for CHF patients for one year was over $182 million. The majority of the patients (73.63%) were female and accounted for 70% of the total cost. The mean age was 70 years and the largest portion of the total cost (55%) came from those 65 years and older. Of the 13,947 patients 11,065 (79%) were hospitalized at an average cost of $4,679 per hospitalized patient. Approximately 87% of the study population received prescription drugs at an average cost of $2,897 per prescription drug user. Hospitalizations and prescription drugs contributed 28% and 19.38% respectively to the total cost. Almost one third of the total cost was due to long-term care at $13,817 per utilizer. Costs for CHF diagnosis related claims were 14% of all costs. **CONCLUSION:** CHF represents a significant financial burden from the perspective of the Louisiana Medicaid program. Improved management of the condition is needed to reduce the cost of treatment associated with CHF.

PCV10

INCIDENCE OF RHABDOMYOLYSIS IN PATIENTS INITIATED ON HMG CO-A REDUCTASE INHIBITOR THERAPY IN A MANAGED CARE ORGANIZATION

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Recent evidence suggests there is an increased risk of rhabdomyolysis in patients initiated on cerivastatin compared to patients initiated on other HMG CoA reductase